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	155077	A. BUILDING 00 B. WING	10/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW MANOR	45 BEACHWAY DR INDIANAPOLIS, IN46224

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F0000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00096702 and Complaint IN00097819. Complaint #IN00097819-Unsubstantiated, due to lack of evidence. Complaint #IN00096702-Substantiated, Federal/State deficiencies related to the allegations are cited at F325 and F371. Survey dates: October 3, 4, 5, 6 & 7, 2011. Facility number: 000032 Provider number: 155077 AIM number: 100273330 Survey team: Marcy Smith, RN- TC Leia Alley, RN Patti Allen, BSW Karina Gates, Medical Surveyor Courtney Mujic, RN Beth Kolasa, RN (October 3, 4, 5 & 7, 2011) Census Bed Type: SNF/NF: 122 SNF: 23 Total: 145	F0000	Submission of this Plan of correction does not constitute an admission to or an agreement with facts alleged on the survey report. Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Census payor type: Medicare: 23 Medicaid: 96 Other: 26 Total: 145 Sample: 24 These deficiencies also reflect State Findings cited in accordance with 410 IAC 16.2. Quality review completed on October 13, 2011 by Bev Faulkner, RN			
F0241 SS=E	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation and interview, the facility failed to ensure respect for residents' privacy by entering rooms with out knocking. This affected 4 of 145 residents residing in the facility. Residents #11, 53, 54, and D. Findings included:	F0241	I. Employees #5, #4 and #3 were addressed and re-educated regarding ensuring respect for residents' privacy by knocking prior to entering resident rooms upon observation of their failure to do so. II. As all residents could potentially be affected by this practice, the following actions were taken. III. As a means to	10/25/2011

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	1. During initial tour on 10/3/11 at 11:00 a.m. and in the presence of the ADON (Assistant Director of Nursing), Employee #5 was observed entering a resident's room without knocking first . At that time, the ADON asked Employee #5 if she could "re-do that entry." Employee #5 came back to the door and knocked on the resident's door. This affected Resident #'s 53 and 54. During an observation of a wound procedure for Resident # D on 10/5/11 at 10:30 a.m. and in the presence of the ADON and Employee #7, Employee #4 was observed opening the door without knocking first for permission to enter. During an observation of an Accu-check (blood sugar testing) for Resident # 11 on 10/5/11 at 11:10 a.m., Employee #3 was observed entering the resident's room without knocking first. Employee # 3 was then observed at 12:19 p.m., going into the same room to administer insulin without knocking first for permission to enter. A facility policy, undated, and titled "Your Rights As A Nursing Home Resident" indicates residents have the right to be treated with respect and dignity... and have "privacy in your room		ensure ongoing compliance with maintaining an environment that enhances each resident's dignity and respect in full recognition of their individuality, all staff have received inservice training. Said training specifically addressed the need to respect the resident's privacy by knocking prior to entering the resident's room. (See Attachment A) IV. As a means of quality assurance, following the aforementioned inservice training, auditing for compliance shall be completed daily on scheduled days of work by designated administrative/ nursing staff. (See Attachment B) Should noncompliance be noted, corrective action including re-education and disciplinary action, if warranted, shall be implemented. Results of the aforementioned audits and immediate corrective actions taken shall be reported to the quality assurance committee on a quarterly basis for review and recommended revision of monitoring, if warranted.	

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	and during bathing, medical treatment and personal care". 3.1-3(t)			
F0253 SS=E	The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to ensure housekeeping and maintenance services were provided to maintain a clean and sanitary environment including clean windows and failed to ensure carpet was clean and in good repair. This potentially affected 26 of 32 residents residing in the rooms observed. (Rooms A Hall- 8,10, 15, 19,23. B Hall - 5, 9, 23, 24. C Hall- 1,5, 16, 20. D Hall- 16 and 4). Findings include: During the "General Observation" tour conducted on 10-6-11 at 9:30 a.m., with the Maintenance Supervisor, Housekeeping/Laundry Supervisor and Assistant Administrator the following was observed: 1) In resident room A -8, the sliding door glass was soiled with a build up of dirt and different color stains, that made it	F0253	I. The facility has taken corrective actions as follows: 1) Resident room A8 - the sliding glass door was thoroughly cleaned. 2) Resident room A10 – the window glass was thoroughly cleaned. 3) Resident room A15 - the window glass was thoroughly cleaned. 4) Resident room A19 - the window glass was thoroughly cleaned. 5) Resident room A23 – the window glass was thoroughly cleaned. 6) The carpets in corridors on A wing have been shampooed/thoroughly cleaned. 7) Resident room B5- the window glass was thoroughly cleaned. 8) Resident room B9 - the window glass was thoroughly cleaned. 9) Resident room B23 - the window glass was thoroughly cleaned. 10) Resident room B24 - the window glass was thoroughly cleaned. The g-chair has been replaced. 11) In the lounge at the end of corridor B, the windows have been thoroughly cleaned and the carpet shampooed/thoroughly cleaned. 12) Resident room C1 – the toilet	10/25/2011

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	difficult to see through. There were 2 residents that shared this room. 2) In resident room A-10, the window glass had a heavy build up of dirt and different color stains, that made it difficult to see through. There were 2 residents that shared this room. 3) In resident room A-15, the window glass had a heavy build up of dirt and different color stains, that made it difficult to see through. There was 1 resident residing in this room. 4) In resident room A-19, the window glass had a heavy build up of dirt and different color stains, that made it difficult to see through. There were 2 residents that shared this room. 5) In resident room A-23, the window glass had a heavy build up of dirt and different color stains, that made it difficult to see through. There was 1 resident residing in this room. 6) The carpet in the corridors on A-wing had multiple colored and size stains, too many to count. This potentially affected the 29 residents residing on the A wing. During an interview on 10-6-11 at 10:15		was thoroughly cleaned, room/bathroom thoroughly cleaned and window glass thoroughly cleaned. 13) Resident room C5 – the carpet has been replaced. The window glass was thoroughly cleaned. 14) Resident room C16 - the window glass was thoroughly cleaned. 15) Resident room C20 - the window glass was thoroughly cleaned. 16) Resident room D16 – the carpet has been replaced. 17) Resident room D4 – the carpet has been replaced. 18) The rugs observed in the assist dining room were removed upon discovery. II. As all residents could be affected, full house environmental rounds were made and all windows in need of cleaning were thoroughly cleaned. Carpeting throughout the facility has been assessed and scheduled for repair/replacement, as warranted. III. As means to ensure ongoing compliance with ensuring housekeeping and maintenance services are provided to maintain a clean and sanitary environment including, but not limited to, windows and carpets, cleaning schedules have been reviewed to ensure routine inspection and cleaning/ shampooing to be conducted per schedule, with frequency increased if found to be insufficient. IV. As a means of quality assurance, following the aforementioned interventions, auditing for compliance with the	

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	a.m., with the Housekeeping Supervisor, she indicated the windows and the carpet needed to be clean. This potentially affected the 29 residents residing on the A wing. 7) In resident room B-5, the window glass had a heavy build up of dirt and different color stains, that made it difficult to see through. There was 1 resident residing in this room. 8) In resident room B-9, The window glass had a heavy build up of dirt, that made it difficult to see through. There was 1 resident residing in this room. 9) In resident room B-23, the window glass had a heavy build up of dirt and different color stains, that made it difficult to see through. There were 2 residents that shared this room. 10) In resident room B-24, the window glass had a heavy build up of dirt that made it difficult to see through. There was a Geri-chair located near the window bed that had cuts, nicks and scrapes in the upholstery on the armrest. There were 2 residents that shared this room. 11) In the lounge at the end of the corridor on B wing, the windows had a heavy build up of dirt and different color stains,		cleaning schedules shall be completed on a weekly basis by the housekeeping supervisor. (See Attachment C) Should noncompliance with the scheduled cleaning be noted, corrective action, including re-education and disciplinary action, if warranted, shall be implemented. The Administrator shall be responsible to make full facility rounds at least daily on scheduled days of work to confirm compliance with adherence to said cleaning schedules.(See Attachment D) Results of the aforementioned audits/rounds and immediate corrective actions shall be reported to the quality assurance committee on a quarterly basis for review and recommended revision of monitoring, if warranted.	

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	making it difficult to see through. The carpet had multiple colored and size stains, too many to count. During an interview on 10-6-11 at 10:40 a.m., with Housekeeping Supervisor and Maintenance Supervisor they indicated the residents and family members use the lounge. They indicated the windows and the carpet needed to be clean. This potentially affected the 38 residents residing on the B wing. 12) In resident room C-1, the toilet in the restroom had brown smear stains on the top of the seat and around the inside rim. There were food particles on the floor of the rest room. The window glass had a heavy build up of dirt and different color stains, that made it difficult to see through. There were 2 residents that shared this room. In an interview with the Housekeeping Supervisor, she indicated the toilet was stained and soiled. 13) In resident room C-5, there was a 3 inch hole in the carpet. The window glass had a heavy build up of dirt and different color stains, that made it difficult to see through. There were 2 residents that shared this room.			

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	14) In resident room C-16, the window glass had a heavy build up of dirt and different color stains, that made it difficult to see through. There were 2 residents that shared this room. 15) In resident room C-20, The window glass had a heavy build up of dirt and different color stains, that made it difficult to see through. There were 2 residents that shared this room. 16) In resident room D-16, there was a 2 inch hole in the carpet near the restroom door, 1 1/8 inch hole near the entry door and the carpet had raveled 1/8 by 3 1/2 inches located near entrance of the room. There were 2 residents that share this room. 17) In resident room D-4, there was a 3 inch area where the carpet had raveled near the entrance of the room. There were 2 residents that shared this room. 18) In the Assist Dining Room near the exit door, there were 2 rolled up rugs with black rubber backs which had a heavy accumulation of debris, food crumbs,dirt and dust. These rugs were observed 10/4-6/11. During the tour, Resident # 92 indicated because of the dirty windows he did not			

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	get to enjoy his bird feeder and he would like to see them clean. Resident # 25 Indicated she enjoyed watching the birds at the bird feeder located outside her window, but the windows were so dirty now she could barely see out and does not get to enjoy the birds. During a confidential interview, a resident who did not want to be identified, indicated that her windows were very dirty, "I offered to pay them $ 5.00 to clean them. They did not listen, as you see they are very dirty. Some days all I want to do is sit and look out my windows, watch the birds at the bird feeder but I can't see them through these dirty windows." 3.1-19(f)(5)			
F0282 SS=E	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and	F0282	1. A. Please note that Resident B incurred no negative outcomes	10/25/2011

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	interview, the facility failed to ensure plans of care were followed for performing Accuchecks, (Resident #B) administering sliding scale insulin (Residents #B, #10, #135 and #66) and other medications (Resident #96), applying barrier skin cream, (Resident #96) applying TED hose, (Residents #B, #96 and #E) obtaining labs and x-rays as ordered (Residents #130 and #30) and following behavior and restraint care plans (Resident #76 and #130) for 9 of 21 residents reviewed for having their plans of care followed in a sample of 24. Findings included: 1. The record of Resident #B was reviewed on 10/3/11 at 2:00 p.m. Diagnoses for Resident #B included, but were not limited to, high blood pressure, diabetes mellitus, congestive heart failure, coronary artery disease (CAD) and edema. a. A care plan for Resident #B, dated 3/11/11 and updated 9/20/11, indicated a problem of having diabetes mellitus and being at risk for high or low blood sugar. Interventions included "Monitor blood sugar as ordered..." and "Humalog insulin per sliding scale as ordered..." A recapitulated physician's order for		as a result of the findings. Involved nursing staff have been identified and addressed in regard to failure to check the resident's blood sugar as ordered and/or administer insulin coverage as per order. B. Staff responsible for the placement of thigh high TED hose on Resident B was addressed upon discovery that said TED hose were not in place as per order. 2. A. The clinical record of Resident #96 was reviewed and responsible caregivers on dates on which the medication was omitted were identified and addressed regarding the same. Please note that the resident incurred no negative outcome as a result of the omitted doses. B. Staff responsible for the application of TED hose for resident #96 was addressed upon observation of the TED hose not being in place. Staff were also advised as to should the resident choose not to wear the TED hose the same should be documented. 3. A. The caregivers of Resident #76 were addressed in regard to the need to comply with the careplan including keeping the resident's hands busy doing something else; holding book or magazine; crafts/art work, etc., in an effort to deter the resident's behavior of picking at her nose. B. Staff providing care to Resident #76 were addressed upon discovery that no protective skin cream had been applied after the	

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	August, 2011, with an original date of 2/28/11, indicated Resident #B was to have his blood sugar checked 4 times per day, before meals and at bedtime. He was to receive Humalog insulin, depending on the results of his blood sugar check, according to the following sliding scale: Blood sugar of 151 - 200 = 2 units insulin Blood sugar of 201-250 = 4 units insulin Blood sugar of 251 - 300 = 6 units insulin Blood sugar of 301 - 350 = 8 units insulin Blood sugar of 351 - 400 = 10 units insulin Review of a "Blood Glucose Monitoring/Sliding Scale Insulin Verification Record" for Resident #B for August, 2011, indicated the following: On 8/13/11 at 6:30 a.m., his blood sugar was 157. He should have received 2 units of insulin. There was no documentation to indicate any insulin was given. At 9:00 p.m., on this date there was no indication his blood sugar was checked. On 8/14/11 at 6:30 a.m., his blood sugar was 157. He should have received 2 units of insulin. There was no documentation to indicate any insulin was given. On 8/22/11 at 11:30 a.m., his blood sugar was 180. He should have received 2 units of insulin. There was no documentation to indicate any insulin was given. Review of a "Blood Glucose		incontinence care provided to Resident #76, as to the need to adhere to physician's orders in regard to the same. The cream was secured for use, as per order. 4. The caregivers responsible for the care of Resident #E at the time of observations who failed to place TED hose on the resident were addressed regarding the same. 5. The clinical record of Resident #10 has been reviewed and staff failing to conduct blood glucose testing and/or administer sliding scale insulin as per physician order have been addressed. 6. A. Please note the physician of resident #130 was notified in regard to the omitted September CBC. B. The orders of Resident #130, including lap tray to be released during meals on the 7-3 and 3-11 shifts has been reviewed and staff re-educated as to said order. 7. The clinical record for Resident #134 has been reviewed and staff identified and re-educated who failed to administer sliding scale insulin as per physician order. 8. The clinical record for Resident #66 has been reviewed and applicable staff members identified who failed to document the following of the orders for sliding scale coverage as ordered by the physician. 9. The physician of Resident #30 was notified in regard to the omitted lab orders and clarification obtained to ensure any further lab work	

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	Monitoring/Sliding Scale Insulin Verification Record" for Resident #B for July, 2011, indicated the following: On 7/21/11 at 6:30 a.m., there was no indication his blood sugar was checked. On 7/22/11 at 4:30 p.m., his blood sugar was 258. He should have received 6 units of insulin. There was no documentation to indicate any insulin was given. On 7/27/11 at 6:30 a.m., his blood sugar was 170. He should have received 2 units of insulin. There was no documentation to indicate any insulin was given. On 7/28/11 at 4:30 p.m., his blood sugar was 175. He should have received 2 units of insulin. There was no documentation to indicate any insulin was given. Further information regarding the above missing Accuchecks and sliding scale insulin administrations was requested from Regional Consultant #1 on 10/6/11 at 9:00 a.m. On 10/6/11 at 11:00 a.m., Regional Consultant #1 indicated she was not able provide any information the above missing Accuchecks were performed or the sliding scale insulin was administered. b. A care plan, dated 3/11/11 and updated on 9/22/11, indicated a problem of Resident #B being at risk for complications associated with high blood pressure..."Res [resident] has DX		necessary would be completed as per physician order. I. Lab and x-ray orders for all residents have been reviewed in an effort to ensure all ordered labs and x-rays have been obtained, or the physician contacted for further clarification, as warranted. As all residents could be affected, the following corrective actions were taken: II. As a mean to ensure ongoing compliance with ensuring plans of care are followed for performing accuchecks, administering sliding scale insulin, and other medications, applying barrier skin creams, applying TED hose, obtaining labs and x-rays as ordered and following behavior and restraint careplans, nursing staff shall receive inservice training in regard to adherence with conducting of accu-checks and administration of sliding scale insulin as per physician order, obtaining labs and x-rays as per order, application of barrier creams, TED hose, etc., as per order, and following careplanned interventions for restrictive devices and/or behaviors. Administrative nursing staff have identified residents with specific care needs (as listed) and will monitor daily on scheduled days of work for compliance with performing accuchecks, administering sliding scale insulin, and other medications, applying barrier skin creams, applying TED hose, obtaining labs and	

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	[diagnosis] CAD. An intervention was "Thigh high TED hose [elastic stockings which aid in blood flow and help prevent blood clots in the lower extremities] on in AM, off PM." During an observation and interview with Resident #B on 10/5/11 at 11:30 a.m., he was not wearing any TED hose. He indicated at this time "I don't mind wearing them, they just never put them on me." 2. Resident #96's clinical record was reviewed on 10/3/2011 at 11:00 a. m. The record contained documentation of Resident #96 having been admitted to the facility on 7/1/2010. The record contained diagnoses that included, but were not limited to, chronic obstructive pulmonary disease, gastroesophageal reflux disease, hypertension, anemia, dementia, and anxiety.		x-rays as ordered and following behavior and restraint careplans. (See Attachments E and F)III. As a means of quality assurance, following the aforementioned inservicing training, auditing for compliance shall be completed on scheduled days of work by designated administrative/ nursing staff. Should noncompliance be noted, corrective actions including re-education/ disciplinary action, if warranted shall be implemented. The assigned nurse consultant/designee shall be responsible to visit the facility on, at least, a twice weekly basis to confirm compliance. (See Attachments G1-G5) Results of the aforementioned audits and immediate corrective actions taken shall be reported the quality assurance committee on quarterly basis for review and recommend revision of monitoring, if warranted.	

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	a. Resident #96's clinical record included a Physician's order for Omeprazole DR 20 MG capsule by mouth daily before breakfast dated 6/27/2011. The clinical record included a Medication Administration Record (MAR) indicated doses were not documented as given for the medication Omeprazole on the following dates; 9/4/2011 9/5/2011 9/6/2011 9/19/2011 9/20/2011 9/25/2011 The missing documentation of the medications was brought to the attention of the Director of Nursing during an interview on 10/5/2011 at 3:45 p.m. She indicated that she wasn't sure why there was missing documentation on Resident #96's MAR and that it could be that the medication wasn't given but the nurses are supposed to circle the blank space. No additional information was provided. Review of the medication administration policy and procedure provided by the Regional Consultant #1 on 10/6/2011 at 4:40 p. m., indicated, "medication administration will be recorded on the MAR after given." The policy also			

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	indicated, "refusal of medications will be identified by circling the nurses or QMA's initials and documenting on the back of the MAR/TAR the date, time and reason, if known." b. Clinical record review indicated that Resident #96 had a physician's order, dated 7/1/2010, for TED hose (compression stockings) knee high on in a. m. and off at bedtime. An interview and observation with LPN #13 on 10/3/2011 at 2:40 p. m., indicated that Resident #96 was not wearing the TED hose and did not want to wear the TED hose. Resident #96 was also observed on the following dates and times to be not wearing any TED hose; 10/4/2011 at 3:42 p. m. 10/5/2011 at 11:40 a. m. 10/6/2011 at 10:05 a. m. Interview with the Director of Nursing on 10/5/2011 at 4:45 p. m., indicated that nursing staff should be documenting each day that Resident #96 does not want to wear the TED hose. Further documentation was requested during the interview but none was provided. 3. a. Resident #76's clinical record was			

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	reviewed on 10/4/2011 at 10:00 a. m. The record contained documentation of Resident #76 having been admitted to the facility on 5/17/2005. The record contained diagnoses that included, but were not limited to, gastroesophageal reflux disease, hypertension, anemia, dementia, anxiety and glaucoma. Clinical record review of the care plan titled, "behaviors: socially inappropriate," indicated that the last handwritten date it had been updated was 8/18/2011. Under problem was handwritten, "picking her nose constantly." Interventions included, keep her busy (hands) doing something else; reading (holding book or magazine), craft/art work, and under discipline for this intervention was written 'all.' Observations of Resident #76 were completed on the following dates and times and indicated that the resident was sitting in a wheelchair in the hallway in front of C wing nurse's station and did not have anything in her hands or lap to keep her busy; 10/4/2011 at 4 p. m. 10/5/2011 at 10:30 a. m., 11:40 a. m., and 3:57 p. m. 10/6/2011 at 10:00 a. m. During interview with the Director of Nursing and Administrator on 10/6/2011			

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	at 5:10 p. m. during the daily exit conference, any further information regarding Resident #76's behavior care plan interventions was requested. No additional information was provided. b. Clinical record review of the October 2011 physician's recapitulation orders provided by Regional Consultant #1 on 10/5/2011 at 11:10 a. m., indicated, "Riley's butt cream 195 GM apply to buttocks every shift dated 7/27/2010." Review of the care plan titled, "pressure ulcer risk," indicated the last date updated was 8/18/2011, under nursing interventions, "apply preventative topical medication as ordered." Observation of CNA #10 and LPN #11 providing perineum bowel incontinence care on 10/5/2011 at 1:05 p. m., indicated that no protective skin cream had been previously applied or was applied after incontinence care to Resident #76's buttocks. Observation of LPN #11 providing pressure ulcer dressing application on 10/5/2011 at 1:35 p. m., indicated that no protective skin cream had been previously applied or was applied after placing the dressing onto Resident #76's buttocks.			

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	Observation of Resident #76's medications in the C wing med cart and interview with LPN #12 on 10/5/2011 at 4:07 p. m., indicated that the resident was out of the Riley butt cream. LPN #12 indicated that he would order it immediately so that he could be sure to have it for his shift, which was 3-11 p. m. During interview with the Director of Nursing and Administrator on 10/6/2011 at 5:10 p. m. during the daily exit conference, any further information regarding Resident #76 not receiving barrier cream as ordered was requested. No additional information was provided. 4. Resident #E's clinical record was reviewed on 10/6/2011 at 2:45 p. m. The record contained documentation of Resident #E having been admitted to the facility on 8/15/2011. The record contained diagnoses that included, but were not limited to, swallowing problems, hypertension, Alzheimer's disease, and atrial fibrillation. Clinical record review of the October 2011 physician's orders recapitulation provided by Regional Consultant #2 on 10/5/2011 at 12 p. m. indicated an order for, "thigh high TED hose bilaterally (compression stockings to both legs) and remove for care."			

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	Observations of Resident #E not wearing any TED hose were completed on the following dates and times; 10/6/2011 at 3:40 p. m. in the Main Lounge sitting up in a wheelchair. 10/7/2011 at 11:10 a. m. laying down in her room. Interview with LPN #9 on 10/7/2011 at 10:00 a. m., indicated she was not sure why Resident #E was not wearing her TED hose 5. The Clinical Record of resident #10 was reviewed on 10/5/11 at 11:00 a.m.. Diagnoses included, but were not limited to, diabetes mellitus and neuropathy. Review of Physician Orders included an order dated 9/13/11 for "Novolog sliding scale accu check 6:00 a.m., 12:00 p.m., 6:00 p.m., 12 a.m. If Blood Sugar (BS) 199 or below Give No Sliding Scale Insulin. If BS 200 to 250 Give 2 Units of Novalog, If BS 251 to 300 Give 3 Units of Novalog, If BS 301 to 350 Give 4 Units of Novalog, If BS below 70 or above 350 Call Physician " Review of a Blood Glucose/Sliding Scale Insulin Verification Record on 10-5-11 at 3:30 p.m., indicated on the following			

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	dates the Sliding Scale Insulin was not given, as ordered by the physician on 9-13-11: September 13, 2011 12:00 p.m. BS = 229. Requiring 2 units and the resident received 0. September 14, 2011 6:00 a.m. BS = 305. Requiring 4 units and the resident received 0. September 14, 2011 12:00 a.m. BS = 320. Requiring 4 units and the resident received 0. September 21, 2011 6:30 a.m. BS = 224. Requiring 2 units and the resident received 0. September 22, 2011 6:00 p.m. Accu Check Not done. September 23, 2011 6:00 p.m. Accu Check Not done. September 27, 2011 6:00 p.m. Accu Check Not done. In an interview with Regional Consultant #1 on 10-6-11 at 4:30 p.m., she indicated after she investigated the situation of the Sliding Scale Insulin being given, she was unable to locate any verification the sliding scale Novalog insulin was given. 6. a) The clinical record for Resident #130 was reviewed on 10/4/11 at 10:00 a.m.			

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	The diagnoses for Resident #130 included, but were not limited to: hypertension, anemia, Alzheimer's dementia, history of right frontal and left temporoparietal intrapatency hemorrhages, congestive heart failure right sided, and chronic renal failure. The October, 2011 physician's recapitulation order indicated a CBC (complete blood count) lab to be drawn monthly for 4 months beginning 6/8/11. The CBC lab results for June, July, and August, 2011 were found in the clinical record. The CBC lab results for September, 2011 could not be found. During interview with the DON on 10/6/11 at 10:25 a.m., she indicated the September, 2011 CBC lab was not drawn for Resident #130. She indicated the facility changed labs in August, 2011 and the order was entered incorrectly at the new lab as every other month instead of X2 (2 times), so the September, 2011 CBC lab was not drawn as ordered. The following care plans for Resident #130 indicated interventions were to monitor labs as ordered: dehydration effective 6/24/11, hypertension effective 4/8/11, congestive heart failure effective 4/8/11, failure to thrive effective 4/8/11, and anemia effective 4/8/11.			

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The Physician's Orders Procedure Policy provided by Regional Consultant #1 on 10/6/11 at 4:40 p.m., indicated orders, such as make appointments, order labs, and notify pharmacy are to be followed through to completion.

b) The October, 2011 physician's recapitulation order indicated Resident #130's lap tray was to be released during meals on the 7 a.m. to 3 p.m. shift and the 3 p.m. to 11 p.m. shift.

During observation of the dinner meal on 10/5/11 at 6:05 p.m., Resident #130's lap tray was observed to be on while eating dinner. During observation of the lunch meal on 10/6/11 at 12:58 p.m., Resident #130's lap tray was observed to be on while eating lunch.

During interview with the DON on 10/6/11 at 10:32 a.m., she indicated she saw Resident #130 with her lap tray on at dinner on 10/5/11 and that it should have been off. She indicated she guessed they just forgot to take it off.

The Physical Restraint Use and Application Policy provided by Regional Consultant #1 on 10/6/11 at 4:40 p.m., indicated the application of a restraint is to apply restraint as ordered.

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	7. The clinical record for Resident #135 was reviewed on 10/4/11 at 2:00 p.m. The diagnoses for Resident #135 included, but were not limited to: diabetes mellitus type II, hypertension, and hyperlipidemia. A recapitulation of August, 2011 physician's order indicated Accuchecks to be done 4 times daily (6 a.m., 11 a.m., 4 p.m., and 9 p.m.) effective April 2, 2009 and Humulin to be given per sliding scale based on the results of the Accucheck test as follows: 151-200=1 Unit, 201-250=2 Units, and 251-300=3 Units. The August, 2011 Blood Glucose Monitoring/Sliding Scale Insulin Verification Record for Resident #135 indicated the resident's blood sugars were checked and in the range requiring insulin coverage per sliding scale on the following dates and times: 8/2/11 at 9:00 p.m. = 208 2 Units should have been administered and 0 were. 8/4/11 at 4:30 p.m. = 163 1 Unit should have been administered and 0 were. 8/5/11 at 6:30 a.m. = 200 1 Unit should have been administered and 0 were. 8/5/11 at 9:00 p.m. = 286 3 Units should have been administered and 0 were.			

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	8/7/11 at 9:00 p.m. = 196 1 Unit should have been administered and 0 were. 8/15/11 at 9:00 p.m. = 207 2 Units should have been administered and 0 were. 8/16/11 at 9:00 p.m. = 292 3 Units should have been administered and 0 were. 8/28/11 at 9:00 p.m. = 158 1 Unit should have been administered and 0 were. During interview with DON on 10/5/11 at 5:10 p.m., she indicated there was no information to indicate why the incorrect doses were given on the above dates and times. The current diabetes mellitus care plan effective 5/20/10 for Resident #135 indicated an intervention was to monitor blood sugars as ordered. 8. The clinical record for Resident #66 was reviewed on 10/5/11 at 11:00 a.m. The diagnosis for Resident #66 included, but was not limited to: diabetes mellitus. Recapitulation of a physician order, dated 4/27/11, indicated Humalog (insulin treatment of blood glucose levels) was to be given per sliding scale of subsequent blood sugars (BS) from an Accucheck measurement. The sliding scale was			

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	150-200=2 units of Humalog, BS of 201-250= 4 units of Humalog, BS of 251-300=6 units of Humalog, BS of 301-350=8 units of Humalog, and 351-400=10 units of Humalog. Another physician ordered, also dated 4/27/11, indicate the physician was be notified if BS is greater than 450. A clarification of a physician order, dated 10/5/11, indicated Humalog was to be given per sliding scale of subsequent blood sugars on dates 4/27/11 until 8/4/11. The sliding scale was 150-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units. Another clarification of a physician order also dated 10/5/11, stated Humalog was to be given per sliding scale on dates 8/4/11 through current date. The sliding scale was 150-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, 401-450=12 units, and 451-500=14 units. The August and September Blood Glucose Monitoring/Sliding Scale Insulin Verification Records, indicated the resident's blood sugars (BS) were checked and in the range requiring Humalog insulin coverage per sliding scale, on the following dates and times the treatment area for the blood sugar was blank: 8/11/11 at 6:30 a.m.=319 8 units of			

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	Humalog should have been administered. 8/15/11 at 6:30 a.m.=269 6 units of Humalog should have been administered. 8/16/11 at 6:30 a.m.=248 4 units of Humalog should have been administered. 8/28/11 at 6:30 a.m.= 225 4 units of Humalog should have been administered. 8/16/11 at 11:30 a.m.=317 8 units of Humalog should have been administered. 9/23/11 at 11:30 a.m.= 190 2 units of Humalog should have been administered. 8/2/11 at 4:30 p.m.= 485 14 units of Humalog should have been administered. 8/9/11 at 4:30 p.m.=193 2 units of Humalog should have been administered. 8/11/11 at 4:30 p.m.=307 8 units of Humalog should have been administered. 8/15/11 at 4:30 p.m.=209 4 units of Humalog should have been administered. 9/10/11 at 4:30 p.m.=247 4 units of Humalog should have been administered. 8/3/11 at 9:00 p. m.=342 8 units of Humalog should have been administered. 8/20/11 at 9:00 p.m.=295 6 units of Humalog should have been administered. 8/21/11 at 9:00 p.m.=312 8 units of Humalog should have been administered. 9/3/11 at 9:00 p.m.=341 8 units of Humalog should have been administered. 9/24/11 at 9:00 p.m.=319 8 units of Humalog should have been administered.			

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	9/27/11 at 9:00 p.m.=377 10 units of Humalog should have been administered. 9/29/11 at 9:00 p.m.=232 4 units of Humalog should have been administered. In an interview with the DON on 10/5/11 at 4:20 p.m., she indicated that she could not provide any information indicating that treatment was given for the blood sugars requiring Humalog. On a care plan for a diagnosis of diabetes mellitus, dated 9/20/11, an intervention listed was to monitor blood sugar as ordered and notify physician as ordered. 9. Resident #30's clinical record was reviewed on 10/6/11 at 11:45 a.m. Diagnoses for Resident #30 included but were not limited to, type two diabetes, history of respiratory failure, hypertension (high blood pressure), and hyperlipidemia (high cholesterol levels in the blood). A physician's order written on 8/10/11 indicated Resident #30 was to have a "Cervical Spine (bones of the neck/shoulder area) X-ray" to rule out fracture after a fall. The X-ray was not performed until 8/19/11, 9 days after the order was written.			

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	A physician's order written on 8/23/11 indicated Resident #30 was to have a "BMP, PAB and TSH " (BMP is Basic Metabolic Panel showing blood sugar, calcium levels, kidney function and electrolyte and fluid balances. A PAB is Pre-Albumin, a test for lack of protein and TSH is the thyroid stimulating hormone and indicates how the thyroid is functioning). This lab results were not available for review. A physician's faxed order on 8/12/11 indicated he wanted Resident #30 to have an LFT (liver function test) in 2 weeks. This lab results were not available for review. During an interview with Regional Consultant #1 on 10/6/11 at 4:35 p.m., she indicated she was not sure why it took 9 days to obtain the x-ray of the cervical spine. She also indicated she didn't have access to the computer system and that staff was still looking for results of any such labs, but she did not feel as if they had been done. As of final exit on 10/7/11 at 2:30 p.m. no lab results were provided for review to indicate the lab work had been completed as ordered by the physician.			

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	155077	A. BUILDING 00 B. WING	10/07/2011

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	3.1-35(g)(2)			
F0325 SS=E	Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on clinical record review, observation, and interview the facility failed to ensure residents' weight losses were recognized and dietary recommendations were implemented in a timely manner for 4 of 14 residents reviewed for weight loss or gain in a total sample of 24 residents. (Residents #D, #E, #F and #C) Findings include: 1. Resident #D's clinical record was reviewed on 10/6/2011 at 1:30 p. m. The record contained documentation of Resident #D having been admitted to the facility on 6/23/2011. The record contained diagnoses that included, but were not limited to, diabetes mellitus, end stage renal disease,	F0325	I. 1. The clinical/nutritional status of Resident D has been reviewed by the dietitian and interdisciplinary team to confirm that interventions remain appropriate. 2. The clinical/nutritional status of resident E has been reviewed by the dietitian and interdisciplinary team to confirm that interventions remain appropriate. 3. The clinical/nutritional status of Resident F has been reviewed by the dietitian and interdisciplinary team to confirm that interventions remain appropriate. 4. The clinical/nutritional status of Resident C has been reviewed by the dietitian and interdisciplinary team to confirm that interventions remain appropriate. II. As all residents could be affected, the facility has reviewed with responsible staff the policy in regard to re-weigh of a resident who exhibits a significant weight	10/25/2011

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	hypertension, and anxiety. Resident #D's obtained weights listed in the clinical record was reviewed on 10/6/2011 at 1:30 p. m. and indicated the following; 6/23/2011- 136.5 lbs 7/5/2011- 141.2 lbs 9/13/2011- 123.2 lbs 9/19/2011- 123.2 lbs Clinical record review of Resident #D's nutrition care plan indicated, "goal: resident will maintain weight with no unexplained significant weight changes." An interview with the Registered Dietician on 10/6/2011 at 4:00 p. m., indicated that Resident #D might have weight fluctuations that are to be somewhat expected because he is a kidney dialysis patient and this is common. He is weighed after dialysis at the dialysis center so that his fluid fluctuations are accounted for and his weights will be reliable. Clinical record review of a Registered Dietician note, dated 9/28/2011, indicated, "will recommend 1 Nepro a day to provide additional nutrients due to weight loss and variable intake." An interview with the Consultant #1 on		loss/gain in an effort to ensure accuracy of the obtained weight. An administrative nurse shall be responsible to monitor the weights and to identify any variances of concern and initiate further investigation to ensure weights are accurate and interventions are implemented in a timely manner should a resident validly incur a significant weight loss. III. As means to ensure ongoing compliance with ensuring residents weight losses are recognized and dietary recommendations are implemented in timely manner, the consultant dietitian shall be responsible to exit with facility nursing and administrative staff at the end of each visit. Any recommendations shall be communicated to nursing/administrative staff for communication to the respective physician and to ensure timely follow-thru within 3-5 days of receiving said recommendation. IV. As a means of quality assurance, administrative staff shall ensure that any recommendations made are communicated to the physician in a timely manner and response provided and documented. (See Attachment H) Should noncompliance be noted, corrective action including re-education and disciplinary action, if warranted, shall be implemented. The assigned nurse consultant/ designee shall	

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	10/6/2011 at 4:00 p. m., indicated that there are no other notes or nutrition assessments regarding Resident #D's recent weight loss between the dates of 8/30/2011 and 9/28/2011. Interview with the Director of Nursing on 10/6/2011 at 4:08 p. m., indicated that, "turn around time for dietary recommendations should be a week maximum, nothing is written saying this though." A physician's order, dated 10/6/2011, indicated, "one Nepro per day." 2. Resident #E's clinical record was reviewed on 10/6/2011 at 11:20 a. m. The record contained documentation of Resident #E having been admitted to the facility on 8/15/2011. The record contained diagnoses that included, but were not limited to, diabetes mellitus, hypertension, atrial fibrillation, swallowing problems, and dementia. Resident #E's clinical record contained obtained weights listed as follows; 8/17/2011- 109.5 lbs 9/13/2011- 98 lbs 9/20/2011- 107 lbs 9/26/2011- 104 lbs		be responsible to visit the facility on, at least, a twice weekly basis to confirm compliance with adherence to communication of dietary recommendations in a timely manner. Results of the aforementioned audit and immediate corrective actions taken shall be reported to the quality assurance committee on a quarterly basis for review and recommended revision of monitoring, if warranted.	

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	Review of a Registered Dietitian progress note, dated 9/19/2011,indicated that Resident #E's weight was 98 lbs and, "recommend to increase shakes to three times a day." Review of a care plan, titled nutrition care plan indicated, "goal: resident will maintain weight with no unexplained significant weight changes." An interview with the Registered Dietician on 10/6/2011 at 4:00 p. m., indicated that Resident #E's weight did go back up the following week after the significant weight loss. She didn't have an explanation as to why this might have occurred. An interview with the Consultant #1 on 10/6/2011 at 4:00 p. m., indicated there were no other notes or nutrition assessments regarding Resident #E's recent weight loss. Interview with the Director of Nursing on 10/6/2011 at 4:08 p. m., indicated that "turn around time for dietary recommendations should be a week maximum, nothing is written saying this though." A physician's order, dated 10/6/2011, indicated, "increase mighty shakes to			

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	three times a day." 3. The record of Resident #F was reviewed on 10/6/11 at 10:00 a.m. Diagnoses for Resident #F included, but were not limited to, depression with psychotic features, dementia, diverticulosis, chronic pain, Vitamin B12 deficiency and anemia. A care plan for Resident #F, dated 5/6/11 and updated 7/7/11, 8/3/11 and 9/29/11, indicated he was a risk for increased nutrient requirements secondary to his diagnoses his "progressive weight change... significant weight loss... loss of appetite..." Interventions included "7. House Shake TID [3 times per day]...8. Supplements..." Review of a "Weight History" for Resident #F indicated the following: 5/17/11 weight = 130 6/1/11 weight = 128.0 6/7/11 weight = 113.0 This was a significant weight loss of 11% in 6 days. 6/14/11 weight = 110 6/22/11 weight = 107.0 6/29/11 weight = in hospital 7/6/11 weight = 107 7/12/11 weight = 109 7/18/11 weight = 106.5			

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	7/27/11 weight = 107 8/1/11 weight = 107.5 8/11/11 weight = 113 Review of dietary notes for Resident #F indicated the following: 5/16/11..."Goal is to gain wt.[weight]" There were no dietary notes for June, 2011, when the significant weight loss occurred. 7/5/11 "...Receives shakes TID..." 7/7/11 "Spoke to res [resident] about wt (weight) loss, he does like Mighty Shake. Rec [recommend] [increase] to QID [4 times per day]..." 8/3/11 "...Receives Might Shake TID. Previous rec to [increase] shake to QID. Not ordered. Will rec again." Further information was requested from the Director of Nursing and the Registered Dietician (RD) during an interview on 10/6/11 at 3:40 p.m., regarding why Resident #F's significant weight loss of 11% on 6/22/11 was not addressed and why the RD's recommendation on 7/7/11 to increase Mighty Shakes to QID was not implemented. During this interview with the Director of Nursing, she indicated the June weights "were funky." She indicated they thought either the scales were off or the restorative aide doing the weights was either not			

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	doing them or doing them wrong. She indicated the scales were maintenanced and rebalanced at this time. She indicated the restorative aide who had been doing the weights no longer worked for the facility. She indicated their procedure is for the RD to fill out a recommendation form. One copy went to the DON and the other copy to the unit manager. The unit manager or her designee is then responsible for contacting the physician regarding the RD's recommendation and seeing that an order is written and implemented. She indicated the turnaround time between an RD recommendation and implementation should be no more than 7 days. She indicated during the summer the C wing, where Resident #F resided did not have a unit manager. She indicated "not an excuse, but that is probably what happened." 4. The record of Resident #C was reviewed on 10/4/11 at 9:40 a.m. Diagnoses for Resident #C included, but were not limited to, dementia and pernicious anemia. Resident #C was admitted to the facility on 1/31/11.			

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	A care plan for Resident #C, initiated 4/13/11 and updated 9/29/11, indicated she was at risk for altered nutrition and/or increased nutrient requirements secondary to her diagnoses of dementia and anemia, progressive weight change, significant weight loss and loss of appetite. Goals included weight maintenance without "unexplained significant weight changes." Approaches included a House Shake 2 times per day and "Notify Nursing of significant or progressive weight change." Review of a "Weight History" for Resident #C indicated the following: 2/2/11 weight = 140 2/14/11 weight = 140 2/23/11 weight = 140.3 3/1/11 weight = 141 3/9/11 weight = 140 3/14/11 weight = 140 3/23/11 weight = 138.3 3/30/11 weight = 137.3 4/5/11 weight = 136.3 4/11/11 weight = 135.5 4/20/11 weight = 136 4/27/11 weight = 135.5 5/3/11 weight = 135.3 5/16/11 weight = 135.3 6/1/11 weight = 136.6 6/7/11 weight = 109.5 This is a significant weight loss of 19.8% in 1 week. 6/14/11 weight = 110.0			

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	6/22/11 weight = 110.5 6/29/11 weight = 111.5 Review of "Dietary Notations" for 4/13/11 indicated a recommendation by the Registered Dietician (RD) of supplemental snacks for Resident #C. Review of a Nutritional Assessment Form, dated 5/27/11, written by the RD, indicated Resident #C received supplemental snacks and was "underweight." No further dietary recommendations were made on this date. There were no Dietary Notations or Nutritional Assessments found in Resident #C's record between 5/28/11 and 7/7/11 ,the period of time when the significant weight loss of 19.8% occurred. Review of "Dietary Notations" for 7/8/11, written by the RD, indicated Resident #C had a significant weight loss of 19.8%. "Will rec Mighty Shake TID..." Review of "Dietary Notations" for Resident #C for 7/29/11, written by the RD, indicated "...[no] new order for Mighty Shake per previous...rec, will re-rec Mighty Shake TID..." Review of a "...Quarterly Dietary Progress Note" for Resident #C, written by the RD			

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	on 8/17/11, indicated significant weight loss and "Previous RD rec for Mighty Shake not ordered. Will rec again - Mighty Shake TID [with] meals." Review of physician's orders for Resident #C indicated Mighty Shakes were not ordered until 9/18/11. Review of "Dietary Notations" written by the RD on 9/29/11, indicated Resident #C had a significant weight loss of 25.5 % in 5 months. (4/11/11 - 9/12/11) Further information was requested from the Director of Nursing and the RD during an interview on 10/6/11 at 3:40 p.m. regarding why Resident #C's significant weight loss of 19.8% on 6/7/11 was not addressed and why the RD's recommendations on 7/8/11, 7/29 and 8/17 to start Mighty Shakes to TID were not implemented until 9/18/11. During this interview with the Director of Nursing she indicated the June weights "were funky." She indicated they thought either the scales were off or the restorative aide doing the weights was either not doing them or doing them wrong. She indicated the scales were maintenanced and rebalanced at this time. She indicated the restorative aide who had been doing the weights no longer worked for the			

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	facility. She indicated they thought Resident #C's admission weight of 140 pounds might have been wrong. Resident #C was examined on 12/27/10 by the physician taking care of her prior to her admittance to the facility. During an interview with a medical assistant in this physician's office on 10/6/11 at 10:30 a.m., she indicated Resident's C's weight on 12/27/10 was 139.0 pounds. The DON also indicated on 10/6/11 at 3:40 p.m., their procedure is for the RD to fill out a recommendation form. One copy went to the DON and the other copy to the unit manager. The unit manager or her designee is then responsible for contacting the physician regarding the RD's recommendation and seeing that an order is written and implemented. She indicated during the summer the C wing, where Resident #C resided, did not have a unit manager. She indicated "not an excuse, but that is probably what happened." This federal tag relates to Complaint #IN00096702 3.1-46(a)(1) 3.1-46(a)(2)			

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F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to ensure a resident's heart rates and blood pressures met qualifying parameters prior to giving a blood pressure medication for 1 of 12 residents reviewed for having blood pressure medication parameters in a sample of 24. (Resident #B) Findings included: The record of Resident #B was reviewed on 10/3/11 at 2:00 p.m.	F0329	F 329 I. A. Please note that Resident B incurred no negative outcome as a result of staff failing to assess the resident's blood pressure and pulse prior to administration of the ordered Coreg. II. As all residents could be affected, the following corrective actions were taken: III. All licensed nursing staff have received inservice training in regard to adherence with special instructions including, but not limited to, taking of heart rate and/or blood pressure to ensure the meeting of qualifying parameters prior to administration	10/25/2011

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	Diagnoses for Resident #B included, but were not limited to, high blood pressure, diabetes mellitus, congestive heart failure, coronary artery disease (CAD) and edema. a. A care plan for Resident #B, dated 3/11/11 and updated 9/22/11, indicated a problem of being at risk for complications related to high blood pressure. Interventions included "Administer medications as ordered..." A recapitulated physician's order for August, 2011, with an original order date of 2/16/11, indicated Resident #B was to receive Coreg 3.125 milligrams twice a day. Coreg is a medication used to treat high blood pressure and heart failure. According to the physician's order, the medication was not supposed to be given if the resident's heart rate was less than 60 or his systolic blood pressure was less than 100. Review of a Medication Record for Resident #B for August, 2011, indicated his blood pressure was not checked prior to giving the Coreg at 9:00 a.m. on August 8, 9, 10, 11, 15 and 19, 2011. His blood pressure was not checked prior to giving the Coreg at 5:00 p.m. on August 7, 8, 9, 10, 11, 14, 22 and 24, 2011. His heart rate was not checked prior to		of blood pressure (or other applicable) medication, as ordered by the physician. IV. As a means of quality assurance, following aforementioned inservice training, auditing for compliance shall be completed on scheduled days of work by designated administrative/ nursing staff. (See Attachment G-2) Should noncompliance be noted, corrective action including re-education, disciplinary action, if warranted, shall be implemented. The assigned nurse consultant/ designee shall be responsible to visit the facility on an, at least, twice weekly basis to confirm compliance with the continued monitoring and reporting of monitoring results to administration. Results of the aforementioned audits and immediate corrective actions taken shall be reported to the quality assurance committee on a quarterly basis for review and recommended revision of monitoring, if warranted.	

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	giving the Coreg at 9:00 a.m. on August 14, 15, 18, 19, 22, 23 and 24, 2011. His heart rate was not checked prior to giving the Coreg at 5:00 p.m. on August 17, 2011. On 10/6/11 at 9:00 a.m., further information was requested from Regional Consultant #1 regarding the above missing blood pressures and heart rates taken prior to giving Coreg to Resident #B in August. On 10/6/11 at 11:00 a.m., Regional Consultant #1 indicated they were not able to show his heart rate and blood pressure were checked prior to receiving the Coreg on the above days. 3.1-48(a)(3)			
F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions A. Based on observation and interview, the facility failed to ensure dishes and equipment used to store, prepare food was clean or maintained in a sanitary condition during 1 of 2 kitchen observations. This had the potential to affect 141 of residents who received meals from the kitchen in	F0371	F 371 I. A. 1. The microwave has been replaced. 2. The two large skillets have been replaced. 3. Staff #4 was re-educated as to appropriate handwashing. 4. Staff #1 was re-educated as to appropriate use/touching of equipment/placement of hands and handwashing. 5. Staff #5 was	10/25/2011

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	the facility population of 145. B. Based on observation and interview, the facility failed to ensure food was distributed to residents in a sanitary manner, having the potential to affect 58 of 70 residents eating in the dining room. Findings Include: During the dietary walk through and meal observation on 10/3/11 at 10:35 a.m., with the Dietary Manager the following were observed: A.1. The Microwave interior top and bottom had chipped, flaked, bubbled, loose peeling, and missing paint. The Dietary Manager indicated at this time the equipment was used to prepare residents' food and the loose paint could fall into the residents' food. A. 2. Two of two large size skillets in use had Teflon interior that was loose, peeling and missing. The Dietary Manager indicated at this time the equipment was used to prepare residents' food and the loose Teflon could come off into the residents' food. A. 3. Dietary staff #4 was observed going		re-educated as to appropriate handling of plates, drinking cups, glasses and appropriate handwashing. 6. Appropriate staff was addressed in regard to taking temperatures when food items are placed on the steam table. 7. Staff #4 was addressed in regard to appropriate handwashing procedures after touching face and when wrapping silverware. Dietary staff #2 was re-educated in regard to touching equipment, surfaces and necessary handwashing thereafter. B. 1. LPN #6 has been addressed in regard to the proper handwashing following the touching of one's own face and necessary practices in regard to assisting a resident with meals. The assistant administrator was also addressed in regard to assisting residents without meals without contamination of food items. II. As all residents could be negatively affected, the following corrective actions have been taken: III. All dietary staff have received inservice education in regard to proper handwashing (and frequency), proper preparation of food and handling of equipment in means to maintain a sanitary condition. (See Attachment I)IV. As a means of quality assurance, following aforementioned inservice training, observations for compliance shall be completed on scheduled days of work by the dietary supervisor.	

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	from soiled side of dish machine handling soiled dishes to the clean side and handled clean dishes without washing hands several times. Staff #4 was observed rubbing her face and nose without washing hands and then handled and wrapped silverware. Staff #4 would go in and out of the kitchen several times and did not wash hand when entering the kitchen and would go to handling clean dishes. A. 4. Dietary Staff #1 left the steam table line area, went throughout the kitchen touching various equipment, and surfaces, came back to the steam table line and placed her thumbs and fingers in the middle of plates, on the interior of drinking cups, and bowls, without washing her hands. A. 5. Dietary Staff #5 dropped cups, silverware and other items on the floor, picked them up and went back to handling drinks, making sandwiches, place his thumbs and fingers in the middle of plates, on the interior of drinking cups, and glasses, without washing hands. A. 6. The following items were placed on the steam table without taking temperatures, at 12:15 p.m., Squash casserole, 12:35 p.m., Rice, 12:40 p.m., Chicken.		(See Attachment J) Should noncompliance be noted, corrective action including re-education and disciplinary action, if warranted, shall be implemented. The assigned consultant dietitian shall be responsible to visit the facility on an, at least, bi weekly basis to confirm compliance with ensuring dishes and equipment used are stored, and food prepared in manner to maintain a clean and sanitary environment. Should non-compliance be observed, immediate corrective action, including re-education and disciplinary action, if warranted, shall be initiated. Results of the aforementioned audits and immediate corrective actions taken shall be reported to the quality assurance committee on a quarterly basis for review and recommended revision of monitoring, if warranted.	

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A. 7. Dietary ran out of silverware at 12:35 p.m., and dietary staff stopped the line to wrap silverware then started sending trays without silverware. Staff #4 was observed rubbing her face, and nose without washing hands then handled and wrapped silverware. At 12:55 p.m., again they ran out of silverware, Dietary staff #2 was observed to go throughout the kitchen touching various equipment and surfaces, cooking, and then wrapped silverware without washing hands.

B. During an observation of food being distributed to residents at the lunch meal on 10/4/11 at 12:00 p.m. in the main dining room, the following was observed:

At 12:52 p.m., Licensed Practical Nurse (LPN) #6 rubbed the first 2 fingers of her ungloved right hand across both nostrils on her nose, then picked up a small paper bag holding a piece of bread with her left hand, removed the bread with her thumb and first 2 fingers of her ungloved right hand and placed it on Resident #56's plate at table #2.

At 12:58, LPN #6 picked up a small paper bag holding a piece of bread with her left hand, removed the bread with her ungloved right hand and placed it on

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	Resident #92's plate at table #6. She then picked up a small paper bag containing a cookie, removed the cookie with her ungloved right hand and placed it on Resident #92's plate. At 1:01 p.m., the Assistant Administrator picked up a small paper bag holding a piece of bread with his left hand, removed the bread from the bag with his ungloved right hand, held the bread in his ungloved left hand and buttered it with his right hand, then placing it on Resident #62's plate at table #7. At 1:06 p.m., LPN #6 picked up a small paper bag holding a piece of bread with her left hand, removed it with her ungloved right hand and placed it on Resident #128's plate. At 1:06 p.m., the Assistant Administrator picked up a small paper bag holding a piece of bread with his left hand, removed the bread from the bag with his ungloved right hand and placed it on Resident #143's plate at table #8. During an interview with the Administrator on 10/6/11 at 9:15 a.m., he indicated there were 58 residents eating lunch in the dining room on 10/4/11 who were on diets allowing them to receive a slice of bread.			

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	During an interview with Regional Consultant #2 on 10/5/11 at 5:00 p.m., she indicated staff should not touch residents' food with their bare hands. This federal tag relates to Complaint #IN00096702 3.1-21(i)(3)			
F0428 SS=D	The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. Based on clinical record review and interview, the facility failed to ensure pharmacy recommendations were taken into consideration and relayed to the physician in a timely manner for 1 of 14 residents reviewed for pharmacy recommendations in a total sample of 24 residents. (Residents #96) Findings include: Resident #96's clinical record was reviewed on 10/3/2011 at 11:00 a. m. The	F0428	F 428 I. The pharmacist recommendation for Resident #6 has been communicated to the physician and medication pass times for the Remeron were altered as per consultant pharmacist recommendations. II. As all residents could be affected, the following corrective actions have been taken: III. As a means to ensure ongoing compliance with ensuring pharmacy recommendations are taken into consideration and relayed to the physician in a timely manner, administrative	10/25/2011

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	record contained documentation of Resident #96 having been admitted to the facility on 7/1/2010. The record contained diagnoses that included, but were not limited to, chronic obstructive pulmonary disease, gastroesophageal reflux disease, hypertension, anemia, dementia, depression and anxiety. Clinical record review indicated a physician's order for Remeron 7.5 mg by mouth daily at noon, dated 5/23/2011. Clinical record review indicated that Resident #96 had a pharmacist recommendation dated as received on 8/29/2011 and indicated, "Remeron (mirtazapine) 7.5 mg by mouth daily at noon for depression. Because lower doses of mirtazapine tend to produce more sedation than higher doses, if not already tried, will you please consider changing the order so that her Remeron is administered at bedtime instead of noon." Clinical record review of the medication administration record for the month of September, 2011 indicated that the Remeron was scheduled and given daily at 12 p. m. Interview with the Director of Nursing on 10/5/2011 at 3:45 p.m., indicated that she wasn't sure why the medication pass times		nursing shall be responsible to receive, review and delegate the communication of said recommendations to applicable unit managers/administrative nursing staff who shall be responsible to track the conveyance of the recommendations and responses of the physician to ensure this done in a timely manner (i.e., within 3-5 days of receipt-unless immediate action is warranted by the pharmacist). IV. As a means of quality assurance, the assigned nurse consultant shall be responsible to visit the facility on, at least, twice weekly basis to confirm compliance with follow-up to the pharmacy recommendations by communicating the same to the physician in a timely manner and documenting physician response. (See Attachment K) Should noncompliance be noted, corrective action including re-education and disciplinary action, if warranted, shall be implemented. Results of the aforementioned audits and immediate corrective actions taken shall be reported to the quality assurance committee on a quarterly basis for review and recommended revision of monitoring, if warranted.	

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	for the Remeron doses hadn't been changed. No additional information was provided. 3.1-25(i)			
F0431 SS=E	The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			

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	Based on observation and record review, the facility failed to ensure eye drops and inhalers were marked with first opened dates. This affected Resident #'s 21,31,37, 38, 35, 46, 67, 64, 50, 57, 54, 62, 49, 65, 52, 64, 92, 94, 104, 99, 101, 103, 94, 90, #B, 78, 77, 83, 71, 84, 80, 76, 79, 96, 116, 124, and 145. Findings included: During an observation of facility medication carts on 10/7/11, beginning at 10:30 a.m., the medication cart referred to as "A- back hall", one of two Advair Inhaler diskus belonging to Resident #21 was not labeled with a first open date. During an observation of the medication cart referred to as "B-front hall", 3 of 3 bottles of nasal sprays were not labeled with first open dates for Resident #'s 31, 37, and 38. Also on the same cart, 2 of 2 bottles of eye drops were not labeled with first open dates for Resident #'s 35 and 96. During an observation of the medication cart referred to as "B-back hall", 14 of 22 bottles of eye drops were not labeled with first open dates for Resident #'s 46, 67, 64, 50, 57, 54, 62, 49, 65 and 52. During an observation of the medication	F0431	F 431 I. The eye drops and inhalers for Residents # 21, 31, 37, 38, 35, 46, 67, 64, 50, 57, 54, 62, 49, 65, 52, 64, 92, 94, 104, 99, 101, 103, 94, 90, #B, 78, 77, 83, 71, 84, 80, 76, 79, 96, 116, 124 and 145 were discarded upon discovery of lack of a date as to when the medication was opened for initial use. The medications were replaced at facility cost. II. As all residents could be affected, all medication rooms and medication carts were assessed to ensure all eye drops and inhalers were marked with first open date and corrective action taken as warranted. III. As a means to ensure ongoing compliance with ensuring that all eye drops and inhalers are marked with first date opened, all nursing staff received inservice training in regard to the need to ensure eye drops and inhalers are marked with first open dates in an effort to ensure that they are also discarded per facility policy. (See Attachment L)IV. As a means of quality assurance, following aforementioned inservice training, auditing for compliance shall be completed on scheduled days of work by designated administrative/nursing staff. (See Attachment M) Should noncompliance be noted, corrective actions including reeducation and disciplinary action, if warranted, shall be implemented. The assigned nurse consultant shall be	10/25/2011

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	cart referred to as "C-back hall", 3 of 4 Advair Inhaler diskus were not labeled with first open dates for Resident #'s 92, 94, and 104. Also on the same cart, 7 of 7 bottles of eye drops were not labeled with first open dates for Resident #'s 99, 101, 103, 94, and 90. During an observation of the medication cart referred to as "C-front hall", 14 of 21 bottles of eye drops were not labeled with first open dates for Resident #'s B, 78, 77, 83, 71, 84, 80, 76, and 79. During an observation of the medication cart referred to as "D-back hall", 2 of 3 Advair Inhaler diskus were not labeled with first open dates for Resident #'s 145 and 124. During an observation of the medication cart referred to as "D- front hall", 2 of 6 Advair Inhaler diskus were not labeled with first open dates for Resident # 116 and a resident new to the facility whom had not been assigned a resident identifier. A facility policy, undated, and titled "EYE DROP INSTILLATION PROCEDURE", indicates once a medication is opened it should be tabled with date opened and to "ensure bottle is label with date opened and the date opened is not greater than 90		responsible to visit the facility on, at least, a twice weekly basis to confirm compliance with the dating of eye drops and inhalers with first open dates. Results of the aforementioned audits and immediate corrective actions taken shall be reported to the quality assurance committee on a quarterly basis for review and recommended revision of monitoring, if warranted.	

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	days". 3.1-25(j)			
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on observation, interview, and record review, the facility failed to ensure accurate documentation of the MAR (medication administration record) for 1 resident in a total sample of 24. (Resident #130) Findings include: The clinical record for Resident #130 was reviewed on 10/4/11 at 10:00 a.m. The diagnoses for Resident #130 included, but were not limited to: hypertension, anemia, Alzheimer's dementia, history of right frontal and left temporoparietal intrapatency	F0514	F 514 I. The staff member who documented the removal of the lap tray for Resident #130 during meal in error has been identified and addressed. II. As all residents could be affected, the following actions were taken: III. As a means to ensure ongoing compliance with ensuring accurate documentation of MAR, all nursing staff has been addressed in regard to thoroughly reading the order/directive on the MAR or TAR and visually confirming compliance and/or completion prior to documenting that the task, treatment, intervention, etc., has been done. All residents with devices which should be released during mealtimes (or other similar	10/25/2011

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	hemorrhages, congestive heart failure right sided, and chronic renal failure. The October, 2011 physician's recapitulation order indicated Resident #130's lap tray to be released during meals on the 7 a.m. to 3 p.m. shift and the 3 p.m. to 11 p.m. shift. During observation of the dinner meal on 10/5/11 at 6:05 p.m., Resident #130's lap tray was observed to be on while eating dinner. During interview with the DON on 10/6/11 at 10:32 a.m., she indicated she saw Resident #130 with her lap tray on at dinner on 10/5/11 and that it should have been off. She indicated she guessed they just forgot to take it off. The October, 2011 MAR indicated Resident #130's lap tray was released during meals on the 3 p.m. to 11 p.m. shift on 10/5/11. During interview with the DON on 10/6/11 at 12:22 p.m., she indicated the MAR should not have indicated Resident #130's lap tray was released during meals on the 3 p.m. to 11 p.m. shift on 10/5/11 and that dinner was the only meal served to Resident #130 on 10/5/11 on the 3 p.m. to 11 p.m. shift.		directive) have been identified to ensure the same is addressed on the careplan and the respective assignment sheet, thus, communicated to staff. IV. As a means of quality assurance, following aforementioned inservice training, auditing for compliance shall be completed on scheduled days of work by designated administrative/ nursing staff. (See Attachment G-2) Should noncompliance be noted, corrective action including re-education, disciplinary action, if warranted, shall be implemented. The assigned nurse consultant/ designee shall be responsible to visit the facility on an, at least, twice weekly basis to confirm compliance with the continued monitoring and reporting of monitoring results to administration. Results of the aforementioned audits and immediate corrective actions taken shall be reported to the quality assurance committee on a quarterly basis for review and recommended revision of monitoring, if warranted.	

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	The Medication and Administration Policy provided by Regional Consultant #1 on 10/6/11 at 4:40 p.m. indicated medication administration will be recorded on the MAR after given. During interview with Regional Consultant #1 on 10/6/11 at 4:40 p.m., she indicated the above policy is the policy the facility uses for all orders listed on the MAR including Resident #130's order for the lap tray to be released during meals. 3.1-50(a)(2)			